STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155769	A. BUILDING _____ B. WING _____	R 06/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRISON WOODS HEALTH CAMPUS	4100 N MORRISON RD MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS	{F 000}		

This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 4/30/13.

This visit was in conjunction with the PSR to Complaint IN00127945 investigated on 4/30/13.

Survey dates: June 18,19, 2013

Facility number: 011596
Provider number: 155769
AIM number: 200901690

Survey team:
Karen Lewis, RN, TC
Ginger McNamee, RN
Tina Smith-Staats, RN

Census bed type:
SNF/NF: 54
Residential: 33
Total: 87

Census payor type:
Medicare: 27
Medicaid: 4
Other: 56
Total: 87

Sample: 8

Morrison Woods Health Campus was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the PSR to the Recertification and State Licensure Survey.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE